State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The following is a description of methods and standards for determining payment rates for specific services when payments are made directly to providers under the fee-for-service program. Payments are made in accordance with the Arizona Health Care Cost Containment System Fee-For-Service Provider Manual and are subject to the limitations set forth in Attachment 3.1-A of the State Plan.

- **Outpatient Hospital Services**

  Beginning with dates of service on and after March 1, 1993, AHCCCS shall reimburse hospitals for outpatient acute care hospital services by multiplying covered charges on an approved claim times the hospital-specific outpatient Medicaid cost-to-charge ratio. The cost reporting and claims data used for computation of the cost-to-charge ratio initially is the same as that described for inpatient hospital services in Attachment 4.19-A. Outpatient cost-to-charge ratios are computed for each hospital by determining the charges and costs associated with treating AHCCCS members in an outpatient hospital setting. Operating and capital costs are considered for the outpatient cost-to-charge ratio computations for each hospital. Medical education costs are excluded from the computation of outpatient cost-to-charge ratios because medical education costs are recognized by the inpatient hospital reimbursement methodology pursuant to Attachment 4.19-A.

  Hospitals shall not be reimbursed for for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the admission are included in the tiered per diem payment.

  Outpatient hospital payments shall be subject to the quick pay discounts and the slow pay penalties described in Attachment 4.19-A.

  Annual Update

  AHCCCS shall rebase the outpatient hospital cost-to-charge ratio at least every one to four years using updated Medicare Cost Reports , and claim and encounter data.

  New Hospitals

  New hospitals, as defined in Attachment 4.19-A, will be assigned the statewide average outpatient hospital cost-to-charge ratio.

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Out-of-State Hospitals

Out-of-state hospitals will be paid the lesser of: a negotiated discount rate, the Arizona outpatient hospital statewide average cost-to-charge ratio, or if reasonably and promptly available, the Medicaid rate in effect on the date of service in the state in which the hospital is located.

Specialty Rates

The Administration may negotiate special contracted rates for outpatient hospital services provided in specialty facilities.

Outpatient hospital payments shall be subject to the quick pay discounts and penalties described in 4.19-A.

- **Laboratory Services and X-Ray**

  AHCCCS's capped fee amounts will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.342.

- **Pharmacy Services**

  Reimbursement is subject to the limitations set forth in 42 CFR 447.331 through 447.332.

- **EPSDT Services Not Otherwise Covered in the State Plan**

  AHCCCS reimburses for chiropractor services using a capped fee schedule. Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS.

  AHCCCS reimburses for personal care services using a capped fee schedule. Payment is based on the lesser of the provider's charge for the service or the capped fee schedule established by AHCCCS.

  AHCCCS reimburses for hospice services, including routine home care, continuous home care, inpatient respite care and general inpatient care. Payment is based on the annual hospice rate established by the Health Care Financing Administration.

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- **Organ Transplantation**

  As authorized in Attachment 3.1-E, AHCCCS reimburses for organ transplant services which are medically necessary and not experimental based on a competitive bid and/or negotiated flat rate process in accordance with State law. The rates are inclusive of hospital and professional services. If the service is provided in another state, AHCCCS will pay that state's approved Medicaid rate for the service or the negotiated rate, whichever is lower.

- **Federally Qualified Health Centers (FQHCs)**

  The payment methodology AHCCCS is proposing will be effective October 1, 1997 and will continue through September 30, 2003. It provides a quarterly payment per member per month (PMPM) to all FQHCs in Arizona which have accepted the terms of the payment agreement. Clinics that achieve FQHC status after implementation of the payment agreement will be offered this method of reasonable cost reimbursement. The terms of reimbursement to a new FQHC shall be consistent with the existing agreement with the FQHCs unless there is a justifiable reason to make a change.

  The AHCCCS Office of Managed Care (OMC) will collect the FQHC member month information from the health plans on a calendar quarter basis and review the information for reasonableness based on historic FQHC enrollment. Reports from the health plans to AHCCCS will be due 60 days after the end of the quarter. A check will be generated by AHCCCS for each FQHC that includes the FQHC's calculation of the supplemental payment which is the total member months reported for the FQHC multiplied by the applicable supplemental payment per member per month. AHCCCS will make every effort to provide the payments to the FQHCs approximately one month after the reports are due from the health plans.

  The initial capitation amount will be $1.75 PMPM statewide. This capitation payment is a supplemental payment provided by AHCCCS for all members who are assigned to FQHCs for primary care services, regardless of the payment methodology agreed to between the FQHC and the Health Plan. The payment is made in compliance with the Balanced Budget Act of 1997 which requires states to supplement health plan reimbursement to the FQHCs. The $1.75 will be reduced each year beginning in the contract year ending FY 2000 based on the schedule for phasing out reasonable cost reimbursement in accordance with the Balanced Budget Act of 1997. The PMPM amount with the phase-out percentages applied will be as follows:

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CONTRACT YEAR	PHASE-OUT PERCENTAGE	PMPM AMOUNT
1998 through 1999	No Phase-out	$1.75
2000	95%	$1.66
2001	90%	$1.58
2002	85%	$1.49
2003	70%	$1.23

In addition, for the period October 1, 1996 through September 1997, AHCCCS will pay the $1.75 PMPM to the two FQHCs (El Rio Health Center and Sun Life Family Health Center, Inc.) which elected reasonable cost reimbursement.

AHCCCS will also settle with El Rio Health Center, Sun Life Family Health Center, Inc., and Mountain Park Health Center for the retroactive time period (April 1990 to September 1993) for $.25 on $1.00. The settlement total will be based on the amounts claimed for reimbursement on the cost reports for those FQHCs electing reasonable cost reimbursement for this retroactive period.

- **Christian Science Sanitoria**

There are two types of Christian Science Sanitoria services: inpatient Christian Science Sanitoria services and sanatoria extended care services. Inpatient Christian Science Sanitoria services are considered to be furnished by a sanitorium in its capacity as a hospital. Payment for inpatient Christian Science sanitoria services may be no more than the Medicare cost reimbursement under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Sanitoria extended care services are services furnished by a Christian Science sanitorium in its capacity as a skilled nursing facility. Payment for sanitoria extended care services shall be made in accordance with the AHCCCS fee-for-service payment rates specified in Attachment 4.19-D of the State Plan.

When AHCCCS reimburses for the following services, payment is the lesser of the provider's charge or the capped fee amount established by AHCCCS. AHCCCS reimburses the following services using this methodology:

- **Clinic Services, including Freestanding Ambulatory Surgery Centers, Freestanding Dialysis Centers and Freestanding Birthing Centers**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Rural Health Clinic Services**
- **Migrant Health Center, Community Health Center and Homeless Health Center Services**
- **Home Health Services, including Durable Medical Equipment, Supplies and Prosthetic Devices**
- **Behavioral Health Services**
- **Family Planning Services**
- **Physician Services**
- **Nurse-Midwife services**
- **Pediatric and Family Nurse Practitioner Services**
- **Other Licensed Practitioner Services**
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)
- **Therapies and Related Services**
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services**
- **Private Duty Nurse Services**
- **Christian Science Nurse Services**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

The following is a description of the methods and standards for determining the payment rate for case management services to the target group identified in Supplement 1 to Attachment 3.1-A.

Beginning October 1, 1996, DES/DDD will be reimbursed on a per member, per month basis to provide case management services to persons with developmental disabilities enrolled in the acute care program. The reimbursement rate is the same rate paid for case management services for the developmentally disabled population enrolled in the Arizona Long Term Care System (ALTCS). The ALTCS case management rate was developed using DES/DDD's audited financial data for the ALTCS program for the period July 1, 1995 through June 30, 1996. The case management line item of the audited report captures the following costs for case managers and supervisors: 1) salary; 2) travel; and 3) education. The total is then divided by enrollment for the same period to determine a per member, per month cost.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities based on the following reimbursement methodologies reflected in Tables 1 and 2.

As the Tables 1 and 2 reflect, the methodologies may differ depending on a specific situation. The various situations are whether:

- the services include or exclude professional services.
- the service is provided by the IHS or a tribal facility
- the tribal facility is set up to bill outpatient services with specific coding and requests this format
- based on specific HCFA guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Long Term Care)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Behavioral Health)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

TABLE 2 - '638 TRIBAL FACILITY OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 – Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center (including professional services) (or) Ambulatory Surgery Center (excluding professional services)	1500 / 00090-00098 (or) 1500 / CPT codes	OMB ASC Rate (or) AHCCCS Capped Fee Schedule (Medicare ASC Rate)
	Professional Services (services included in procedure bill)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Long Term Care)	Outpatient Hospital (including professional services (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic(including professional services (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Professional Services (services included in procedure billed)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Eligibility Type	Service	Billing Form/Codes	Reimbursement
	HCBS Services	1500 / HCPCS or AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS specific codes	AHCCCS Capped Fee Schedule
Title XIX (Behavioral Health)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS codes	AHCCCS Capped Fee Schedule